DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

CONSENT FOR HOME VISIT FOR PACE SERVICES EVALUATION

BENEFICIARY NAME	ADDRESS

By this document, I hereby consent to have State/Federal health review personnel conduct a home visit to ensure that the Federal requirements are met and to assist in evaluating the effectiveness and quality of home health services that I receive from the _____.
(Name of PACE Organization)

I understand that consent for this visit is voluntary and none of my rights to confidentiality or privacy are waived by my consent. I have been told and I understand that refusal to consent to a home health visit will have no effect on the level or nature of PACE benefits I am currently receiving.

BENEFICIARY, OR REPRESENTATIVE OF THE BENEFICIARY, SIGNATURE	DATE